2004–2005

Benefits Enrollment Guide for State of Arizona Employees

It's about choice. It's about value. It's about YOU!

state of arizona benefit options

medical • dental • vision • wellness

"Your Health Matters"

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New Hires

Newly-hired and reinstated employees must enroll in benefits coverage within 30 days of their date of hire or reinstatement. There are no exceptions. If you are nearing the end of your 30-day enrollment period and are not able to enroll in your benefits using the Arizona Benefit Options (AzBO) enrollment system, contact your agency benefit liaison before the 30-day enrollment period has elapsed.

The effective date for your benefits coverage is the first of the month following receipt of your properly-completed elections.

Eligibility

State employees regularly scheduled to work 20 hours or more each week (except those listed below) and their eligible dependents may participate in the Arizona Benefit Options (AzBO) program.

Employees not eligible for AzBO benefits include:

- Employees who work less than 20 hours per week; employees in temporary, emergency, or clerical pool positions; patients or inmates employed in State agency institutions; non-State employee officers and enlisted personnel of the National Guard of Arizona as well as employees in positions established for rehabilitation purposes.

Your eligible dependents include:

- Your legal spouse
- Natural, adopted and/or stepchildren under age 19, or under 25 if a full-time student at an accredited educational institution
- Minors under the age of 19 for whom the employee-member has court-ordered guardianship
- Foster children under the age of 19
- Children placed in the employee-member's home by court order pending adoption
- Natural, adopted and/or stepchildren who were disabled prior to age 19.

Please note: If your dependent child is approaching age 19 and is disabled, immediately contact your agency benefit liaison regarding procedures to continue coverage for this dependent. You will need to provide verification that your dependent child has a qualifying permanent disability, in accordance with Social Security Administration (SSA) guidelines, that occurred prior to his or her 19th birthday. Documentation may be required periodically to include a dependent on your plan. Final eligibility will be determined by the ADOA Benefits Office.

Dependent Documentation Requirements

If you are enrolling a spouse or dependent whose last name is different from your own, the dependent's coverage will not be processed until supporting documentation, such as a marriage license (for a spouse), birth certificate, or court order (for dependents), is provided to your agency human resources office. Subsequent verifications may be requested by plan administrators.

Qualified Medical Child Support Order (QMCSO)

If a QMCSO exists, you must elect coverage for your dependent pursuant to the Order. You may not terminate coverage for a dependent covered by a QMCSO.

If You and Your Spouse are State Employees

If both you and your spouse are eligible State of Arizona employees, be sure to take into account the coverage that you each can elect.

- Each of you may elect single medical, dental and/or vision plan coverage **OR**
- One of you may elect family medical, dental and/or vision plan coverage while the other elects no coverage or single coverage **but under no circumstances may an employee elect dual coverage**.

Other Important Information

Pretax Benefits

When your insurance premiums and contributions to your Flexible Spending Account(s) are made on a pretax basis, your taxable income is reduced. This means you will be paying less state, federal and Social Security (FICA) taxes.

Pretax benefits include:

- Medical Premiums
- Dental Premiums
- Vision Premiums
- Supplemental Life Insurance (first $35,000)
- Flexible Spending Accounts

Keep in mind that any reduction in your taxable income could lead to a reduction in your future Social Security benefits. You should consult a tax advisor if you have questions about this matter.

Changing Your Benefits

You may change your benefit elections during the year whenever you experience a Qualified Life Event (QLE).

Qualifying Life Events include but are not limited to:

- Changes in the employee's marital status: marriage, divorce, legal separation, annulment, death of spouse;
- Changes in dependent status: birth, adoption, placement for adoption, death, or dependent eligibility due to age, marriage, student status;
- Changes in employment status or work schedule that affect benefits eligibility for the employee, spouse, and/or dependent;
- Changes in residence that affect available plan options for the employee, spouse, and/or dependent.

Requested benefit changes must be submitted in writing to your agency benefit liaison within 31 calendar days of the event. Failure to request a change within 31 days will result in the denial of benefit changes until the next QLE or Open Enrollment period.

The change must be consistent with the event.

The effective date for benefit changes resulting from birth, adoption, or placement for adoption is the date of the event. The effective date for benefit changes based on all other QLEs is the first or the sixteenth of the month, whichever is earlier, following the date the employee-member submits the requested change, in writing, to his/her agency benefit liaison.

Please consult with your agency benefit liaison to determine whether or not the life event you are experiencing qualifies under the regulations.

Premium Collection

Premium is collected through payroll deduction for those employees actively-at-work, or by personal payment for an employee on a leave without pay status. Premium collected through payroll deductions is collected for insurance coverage in arrears.

Please check with your benefit liaison to confirm the effective date of termination of your coverage.

Personal payment from an employee on a leave without pay status must be received within 10 days of the last date of coverage.

You may suspend your insurance coverage during a leave without pay status; however, you must request that your coverage be suspended at the time you enter a leave without pay status.

The insurance coverage of an individual on leave without pay who fails to pay the insurance premiums or contributions when due shall terminate at 11:59 p.m. on the 1st day of the period covered by the last premium or contribution paid.

Your Contributions to Arizona Benefit Options

Monthly premiums for Arizona Benefit Options are detailed below in the rate charts.

MONTHLY MEDICAL PREMIUMS

	SINGLE				FAMILY			
	IVR/Plan Code	Your Cost	State Cost	Total Premium	IVR/Plan Code	Your Cost	State Cost	Total Premium
Central Region: Maricopa, Gila, Pinal Counties								
RAN+AMN (HMA) EPO	11	$25.00	$312.00	$337.00	12	$125.00	$718.00	$843.00
Schaller Anderson Healthcare(SA) EPO	21	$25.00	$312.00	$337.00	22	$125.00	$718.00	$843.00
UnitedHealthcare (UHC) EPO	01	$35.00	$312.00	$347.00	02	$135.00	$718.00	$853.00
Arizona Foundation (AZF) PPO	25	$140.00	$419.00	$559.00	26	$390.00	$980.00	$1,370.00
UnitedHealthcare (UHC) PPO	03	$150.00	$419.00	$569.00	04	$400.00	$980.00	$1,380.00
Southern Region: Pima, Santa Cruz Counties								
RAN+AMN (HMA) EPO	09	$25.00	$302.00	$327.00	10	$125.00	$692.00	$817.00
Schaller Anderson Healthcare(SA) EPO	19	$25.00	$302.00	$327.00	20	$125.00	$692.00	$817.00
UnitedHealthcare (UHC) EPO	05	$35.00	$302.00	$337.00	06	$135.00	$692.00	$827.00
Arizona Foundation (AZF) PPO	23	$140.00	$376.00	$516.00	24	$390.00	$859.00	$1,249.00
UnitedHealthcare (UHC) PPO	07	$150.00	$376.00	$526.00	08	$400.00	$859.00	$1,259.00
Northern Region: Yavapai, Coconino, Navajo, Apache Counties								
RAN+AMN (HMA) EPO	15	$25.00	$420.00	$445.00	16	$125.00	$988.00	$1,113.00
Arizona Foundation (AZF) PPO	29	$140.00	$443.00	$583.00	30	$390.00	$1,068.00	$1,458.00
Southeastern Region: Graham, Greenlee, Cochise Counties								
RAN+AMN (HMA) EPO	13	$25.00	$420.00	$445.00	14	$125.00	$988.00	$1,113.00
Arizona Foundation (AZF) PPO	27	$140.00	$443.00	$583.00	28	$390.00	$1,068.00	$1,458.00
Western Region: Mohave, La Paz, Yuma Counties								
RAN+AMN (HMA) EPO	17	$25.00	$420.00	$445.00	18	$125.00	$988.00	$1,113.00
Arizona Foundation (AZF) PPO	31	$140.00	$443.00	$583.00	32	$390.00	$1,068.00	$1,458.00
Out-of-State								
Beech Street PPO	33	$25.00	$558.00	$583.00	34	$125.00	$1,333.00	$1,458.00

MONTHLY DENTAL PREMIUMS

	SINGLE				FAMILY			
	IVR/Plan Code	Your Cost	State Cost	Total Premium	IVR/Plan Code	Your Cost	State Cost	Total Premium
Employers Dental Services (EDS)	09	$3.54	$6.18	$9.72	10	$16.72	$11.50	$28.22
Fortis Dental	01	$4.68	$6.18	$10.86	02	$18.02	$11.50	$29.52
Delta Dental	03	$12.10	$15.40	$27.50	04	$45.90	$43.50	$89.40
MetLife Dental	07	$12.10	$15.40	$27.50	08	$42.46	$43.50	$85.96

MONTHLY VISION PREMIUMS

Avesis Vision	IVR/Plan Code	SINGLE	IVR/Plan Code	FAMILY
Your Cost	05	$6.34	06	$17.18

MONTHLY PREMIUMS - SUPPLEMENTAL LIFE PLAN

Your Age	Your Cost per $5,000 of Coverage
29 and under	$0.50
30-34	$0.60
35-39	$0.70
40-44	$1.20
45-49	$1.60
50-54	$2.60
55-59	$3.70
60-64	$6.70
65-69	$6.70
70+	$10.60

MONTHLY PREMIUMS - DEPENDENT LIFE PLAN

Coverage Amount	Plan Code	Your Cost
$2,000	01	$0.94
$4,000	02	$1.88
$6,000	03	$2.82
$12,000	04	$5.64
$15,000	05	$7.06

BIWEEKLY PREMIUMS - SHORT-TERM DISABILITY PLAN

Your Cost
$0.89 per $100 of your biweekly base salary Biweekly premium = (Biweekly base salary/100) x $0.89 Example: Biweekly base salary = $1,000; Biweekly premium = ($1,000/100) x $0.89 = $8.90 per pay period

Medical Plan Options

We offer two different types of medical plans from which to choose. These plans are:

- Exclusive Provider Organization (EPO)
- Preferred Provider Organization (PPO).

How the Plans Work

EPO – Exclusive Provider Organization

An EPO provides benefits at a lower cost to you as long as you use contracted network physicians and hospitals. In general, an EPO does not pay benefits for care received outside of the EPO network. A network includes physicians, hospitals and other health care providers and facilities.

Your care may be coordinated through your Primary Care Physician (PCP) or you may be able to seek treatment directly from a specialist. In this way the Arizona Benefit Options EPO plans are more flexible than traditional HMO plans.

Some important features of EPO plans are:

- No deductibles
- Minimal copayment
- No charge if you are admitted to a hospital
- No claim forms to complete.

PCP Selection
As an EPO member, you need to select a Primary Care Physician (PCP). You may change your PCP by contacting your plan administrator.

If you are a newly-hired employee, you may enter your PCP's Identification Number during your benefits enrollment process. If you do not select a PCP, one will be assigned to you by the plan administrator.

PCP provider directories, which include PCP identification numbers, may be obtained from your agency human resources office or the ADOA Benefits Office.

It is important to have a PCP who can coordinate your medical care and who can help you make important medical decisions. The selection of a PCP is necessary as a feature of the EPO; however, it is not necessary to obtain a referral, from your PCP, for an office visit to a specialist.

PPO – Preferred Provider Organization

The PPO plan has two levels of out-of-pocket costs: a lower level of costs when you use PPO providers and a higher level of costs when you use non-PPO providers. Under the PPO plan, you are not required to obtain a referral for covered medical services.

Some important features of PPO plans are:

- Copayments may apply to in-network services.
- Deductibles and out-of-pocket payments apply to most out-of-network services.
- You may go directly to any specialist you choose.
- If a network provider is not available in the specialty required for your condition, you must contact your plan administrator for authorization to obtain out-of-network services.

Transition of Care

Transition of Care (TOC) ensures there is no interruption of your health care if you are under care for an acute, chronic or serious health condition, or you are in either the second or third trimester of a pregnancy. TOC allows you to continue treatment with a non-network practitioner at the time of enrollment in a new plan. The State will provide a reasonable transition period for you to continue your course of treatment with the non-network practitioner. This benefit applies only to treatment provided or ordered by the practitioner who is approved by the plan administrator. After this transition period, or after your treatment is complete, whichever occurs first, your medical care must be provided by a network provider to receive the in-network level of benefits.

If you need to request transition services, please contact your plan administrator for further information and required forms.

Guest Privileges

If a person covered under the plan is living away from home, such as a child attending college, or if you need to seek care outside your primary service area, covered in-network services may be available from participating providers. For specific details, please contact your plan administrator.

Plan Administrators

The plan administrator is Arizona Benefit Options – Harrington for the following networks:

- Arizona Foundation
- RAN+AMN (HMA)
- Schaller Anderson Healthcare
- Beech Street

The plan administrator for the UnitedHealthcare network is UnitedHealthcare.

Contact information for the plan administrators may be found on the inside back cover of this Guide.

Medical Provider Profiles

Employees residing in Arizona have a choice of two or more of the following medical networks based on where they live.

- Arizona Foundation
- RAN+AMN
- Schaller Anderson Healthcare
- UnitedHealthcare

The following demographic and hospital comparison charts and key provider messages are offered to aid you in your option selection. Please refer to the AzBO website at *www.benefitoptions.az.gov* for more detailed information about each plan option.

Coverage Facts

		RAN+AMN	Schaller Anderson Healthcare	UnitedHealthcare	Arizona Foundation
Plan Offering	Central Region	EPO	EPO	EPO/PPO	PPO
	Southern Region	EPO	EPO	EPO/PPO	PPO
	Other Regions	EPO	Not offered	Not offered	PPO
Years in business		23	17	27	34
Arizona network doctors	Central Region	4,232	6,325	3,850	6,060
	Southern Region	1,238	1,705	1,588	1,656
	Other Regions	1,297	Not offered	Not offered	1,621
Doctor office locations	Central Region	6,812	8,329	7,074	11,698
	Southern Region	1,653	1,838	2,430	2,504
	Other Regions	1,644	Not offered	Not offered	2,220
Arizona hospitals in network	Central Region	46	31	33	30
	Southern Region	15	7	11	7
	Other Regions	25	Not offered	Not offered	20
Arizona urgent care centers in network	Central Region	25	29	22	30
	Southern Region	3	5	3	9
	Other Regions	13	Not offered	Not offered	14
Members served in Arizona		365,000	700,000	511,000	207,500
Current Clients		Banner Health	America West Airlines	America West Airlines	City of Tempe
		Wells Fargo	Banner Health	Southwest Airlines	Scottsdale Healthcare
		Raytheon	Bashas' Supermarkets	PETsMART	Navapache Reg Med Cntr
		Navajo Nation	Scripps Medical Plans	Carondelet Health Network	Yuma Reg Med Cntr
		QuickTrip Stores	Salt River Project	Insight Enterprises	National Bank of Arizona

Network Hospitals

		RAN+ AMN	Schaller Anderson Healthcare	United Healthcare	Arizona Foundation
Central Region	Arizona Heart Hospital	X	X		X
	Arizona Surgical Hospital	X			
	Arrowhead Community Hospital		X		X
	Banner Baywood Heart	X	X	X	X
	Banner Desert Medical Center	X	X	X	X
	Banner Good Samaritan Medical Center	X	X	X	X
	Banner Mesa Medical Center		X	X	X
	Banner Thunderbird	X	X	X	X
	Boswell Memorial Hospital (Sun Health)	X	X	X	X
	Casa Grande Regional Medical Center	X	X	X	X
	Chandler Regional Hospital		X	X	X
	City of Hope Good Samaritan		X	X	X
	Cobre Valley Hospital	X	X	X	X
	Del E. Webb Memorial Hospital (Sun Health)	X	X	X	X
	John C. Lincoln (Deer Valley and North Mountain)		X	X	X

Network Hospitals (cont'd)

		RAN+ AMN	Schaller Anderson Healthcare	United Healthcare	Arizona Foundation
Central Region (cont'd)	Maricopa Medical Center		X		
	Maryvale Hospital Medical Center	X	X		X
	Mayo Clinic and Hospital	X			X
	Mesa General		X	X	X
	Paradise Valley Hospital	X	X	X	X
	Payson Regional Medical Center	X	X		X
	Phoenix Baptist Hospital and Medical Center	X	X	X	X
	Phoenix Children's Hospital	X	X	X	X
	Phoenix Memorial	X	X	X	X
	Scottsdale Healthcare (Shea and Osborn)	X	X	X	X
	St. Joseph's Hospital and Medical Center (Phoenix)		X	X	X
	St. Luke's Medical Center		X	X	X
	Tempe St. Luke's Hospital		X	X	X
	West Valley Hospital Medical Center	X	X		X
	Wickenberg Regional Medical Center	X			X
Southern Region	Carondelet St. Joseph's Hospital	X	X	X	X
	Carondelet St. Mary's Hospital	X	X	X	X
	Carondelet Holy Cross Hospital	X	X	X	X
	Cornerstone Hospital of SE Arizona			X	
	El Dorado Hospital	X		X	X
	Kino Community Hospital	X		X	
	Northwest Medical Center			X	X
	Tucson Heart Hospital		X	X	X
	Tucson Medical Center	X	X	X	X
	University Medical Center	X	X	X	X
Northern Region	Dixie Regional Medical Center, St. George, Utah	X			
	Flagstaff Medical Center	X			X
	Kane County Hospital, Kanab, Utah	X			
	Navapache Regional Medical Center	X			X
	Page Hospital	X			X
	Rehoboth McKinley Hospital, Gallup, New Mexico	X			
	Sage Memorial Hospital	X			X
	Verde Valley Medical Center	X			X
	White Mountain Regional Medical Center	X			X
	Winslow Memorial Hospital	X			X
	Yavapai Regional Medical Center	X			X
Southeastern Region	Benson Hospital	X			X
	Copper Queen Hospital	X			X
	Mt Graham Regional Medical Center	X			X
	Northern Cochise Community Hospital	X			X
	Sierra Vista Regional Health Center	X			X
	Southeast Arizona Medical Center	X			X
Western Region	Colorado River Medical Center, Needles, California	X			X
	Havasu Regional Medical Center	X			X
	Kingman Regional Medical Center				X
	La Paz Regional Hospital	X			X
	Palo Verde Hospital, Blythe, California	X			
	Western Arizona Regional Medical Center	X			X
	Yuma Regional Medical Center	X			X

A Word from Our Providers:

Arizona Foundation
As Arizona Benefit Options only statewide PPO option, we are the largest, oldest and most recognized statewide network with 9,337 providers in 16,322 locations.

If you need to seek care outside the primary service area, covered services are available from participating providers in the national provider network.

Our providers are contracted on a calendar-year basis and providers are not permitted to drop out during the year. This ensures network stability.

We offer Mayo Clinic doctors and Mayo Hospital.

RAN+AMN
We are Arizona's Exclusive Provider Organization (EPO) in all Arizona counties. RAN is Rural Arizona Network. It serves all Arizona counties except Maricopa and Pima. AMN is Arizona Medical Network serving Maricopa and Pima counties. If you need to seek care outside the primary service area, covered services are available from participating providers in the national provider network.

Together, RAN+AMN have provided accessibility, convenience, and availability to the employees and families of self-funded employers, just like the State of Arizona, for the past 20 years.

The RAN+AMN EPO network is one of the least expensive plans in the Arizona Benefit Options program. RAN+AMN EPO option not only costs less but you and your family gain the fullest range of carefully screened and monitored providers and hospitals without losing any benefits.

Schaller Anderson Healthcare
With headquarters in Phoenix and serving all of Arizona for more than 17 years, we live and work in the same communities as you and your family.

With more than 8,000 physicians in 10,000 locations throughout central and southern Arizona, it is very likely that your doctors are already members of the Schaller Anderson Healthcare Network. If you need to seek care outside the primary service area, covered services are available from participating providers in the national provider network.

We are selective about who can participate in the Schaller Anderson Healthcare Network. We credential each provider in our network and review his/her professional background before the provider can see a member.

UnitedHealthcare
United Healthcare provides you and your dependents national reciprocity. You have access to our nationwide network of over 420,000 physicians and 3,700 hospitals across the country.

In Arizona, you can access United Healthcare's network of over 9,500 private practice physician offices and 58 hospitals.

We have been providing coverage since 1974 and insure one in seven residents in the State of Arizona.

Arizona Benefit Options Medical Plans Comparison Chart

	EPOs	PPOs	
These plans are available to employees statewide.	• **RAN+AMN EPO**	• **Arizona Foundation PPO**	
In addition to the plans above, the following plans are offered to employees in Maricopa, Gila, Pinal, Pima and Santa Cruz counties.	• **Schaller Anderson Healthcare EPO** • **UHC Select EPO**	• **UHC Options PPO**	
DEDUCTIBLES/MAXIMUMS	**In-Network (Copayments)**	**In-Network (Copayments)**	**Out-of-Network (Out-of-Pocket)**
PCP REQUIRED FOR EACH MEMBER?	Yes	No	No
PCP REFERRAL REQUIRED TO SEE A SPECIALIST?	No*	No	No
PLAN YEAR DEDUCTIBLES Individual	None	None	$300
Family	None	None	$600
OUT-OF-POCKET MAXIMUMS Individual	None	$1,000	$3,000
Family	None	$2,000	$6,000
LIFETIME MAXIMUMS	None	None	$2,000,000
PHYSICIAN SERVICES Office visits/consultations, Specialist visits/consultations	$10 copay Max of 1 copay/day/provider	$10 copay Max of 1 copay/day/ provider	30%
PREVENTIVE CARE Well Baby, Child and Adult Physical Exams, Annual Well-Woman Exams (GYN visit & Pap smear test), Annual Well-Man Exams (Office visit & PSA blood test), Adult Immunizations (e.g., pneumonia, flu)	$10 copay/visit	$10 copay/ visit	Not covered
Mammography Screening (Coverage based on patient age or need)	None	None	30%
OUTPATIENT SERVICES Freestanding ambulatory facility or hospital outpatient surgical center	None	None	30%
HOSPITALIZATION SERVICES Room & Board (private room when medically necessary)	None	None	30%
Intensive Care	None	None	30%
Surgeons and Assistants, Anesthesiologists, Pathologists, Radiologists	None	None	30%
EMERGENCY CARE Urgent Center Care	$20 copay	$20 copay	30%
Emergency Room	$75 copay waived if admitted	$75 copay waived if admitted	$75 copay waived if admitted
Ambulance (for medical emergency or required interfacility transport)	None	None	Emergency paid at in-network benefit rate
PRESCRIPTION DRUGS Copays apply for in-network pharmacies only			
Retail: up to 30-day supply per copay Online/Mail Order: up to 90-day supply for two copays			
• Generic	$10 copay	$10 copay	$10 copay
• Preferred Brand	$20 copay	$20 copay	$20 copay
• Non-Preferred Brand	$40 copay	$40 copay	$40 copay

*Some EPOs require referral for particular types of specialists.

Pharmacy

Prescription drug benefits are available through the Walgreens Health Initiatives (WHI) network which consists of more than 54,000 participating chain and independent pharmacies nationwide. There are approximately 900 member pharmacies within the State of Arizona including but not limited to:

Albertsons
Bashas'
CVS Pharmacy
Costco
Eckerd
Food 4 Less
Food City
Fry's
Kmart
Longs Drugs
Osco Drugs
Rite Aid
Safeway
Sam's Club
Smith's
Target Pharmacy
United Drugs
Vons
Wal-Mart
Walgreens
Winn-Dixie

For a complete list of participating pharmacies, and to find a participating pharmacy near you, please refer to our website, www.benefitoptions.az.gov.

The plan administrator of the pharmacy program is Walgreens Health Initiatives (WHI).

Mail Order Prescription

WHI also provides a mail order service for those members who prefer the convenience of mail order or for members who need monthly medications for chronic or long-term health conditions, such as high blood pressure or diabetes. The mail order distribution center is located in Tempe, Arizona to ensure quick delivery of your medications.

- You may request up to a 90-day supply of maintenance medications for only two copays.
- Multilingual customer service representatives are available via a toll-free number 24 hours a day, 7 days a week to provide assistance.
- One-on-one consultations with licensed pharmacists are available via a toll-free number. They will answer any questions, address any concerns you may have.
- You may charge your copay amount to your Visa, MasterCard, American Express or Discover account. Payment by personal check is also accepted.
- You may register your email address to receive notifications of your medication order, order status and shipping methods.
- WHI must receive a new prescription from your provider before mail order service can be initiated.
- To order refills, you can log on to www.benefitoptions.az.gov and select the pharmacy link or use convenient touch-tone phone service 24 hours a day, 7 days a week. TTY service is also available.

About This Guide

The information in this Guide provides a brief overview of your State of Arizona benefits. It is not intended to provide complete details. Details of the plans are contained in the plan description.

The State of Arizona reserves the right to change or terminate any of its plans, in whole or in part, at any time.

Online Access to Information

All of the Arizona Benefit Options plans feature web sites that give you access to the kinds of information and transactions that are state-of-art for the health care industry. No matter what plan you choose, you will have a website that offers personalized information on:

- Claim status
- EOB (explanation of benefits) information
- Amount of deductibles met
- Status of your prescriptions
- Mail order drug service information and processing
- Drug facts and precautions
- Information about participating network providers
- Information on diseases and physical conditions
- News and health-related articles.

You can learn a great deal by visiting your plan's site. Many people find that the web is so fast and easy that it becomes their first choice for finding out health and plan-related information.

Once your coverage takes effect, you will have full access to your plan's site and your personalized information within the site. You will need to register for these sites on your first visit and establish your own username and password. All personal data on these sites is protected by encryption that meets industry standards.

As with all the Benefit Options online features, you may get to your personal information by logging on to www.benefitoptions.az.gov.

Help Managing Serious Medical Conditions

Being diagnosed and living with a serious medical condition can be very difficult. All of the Arizona Benefit Options medical plans feature a disease management program. This program helps people with certain medical conditions better manage their illness and make their lives more fulfilling.

In these disease management programs, you work directly with a clinician who has expertise in your medical condition. This person can help you to better understand your treatment plan, follow your treatment plan, and ensure that you have the equipment needed to monitor and manage your condition.

Covered plan members in all of the Arizona Benefit Options medical plans can receive help through their plan's disease management program. Our plans offer disease management that meets rigorous clinical standards for the following four conditions:

- Asthma
- Congestive Heart Failure (CHF)
- Diabetes
- Perinatal Care.

Highly effective disease management programs are emerging constantly, and more of these programs will be added to Benefit Options in the future.

If you have been or are diagnosed with one of these diseases and you want to learn more about disease management, contact your plan administrator. Additionally, if you are diagnosed with one of these conditions, you may receive a call from a clinician, who works for your medical plan, offering help.

Participation in a disease management program is voluntary. However, a large majority of patients who do participate in such a program find such participation a valuable resource as they navigate the complex world of today's health care.

Dental Plan Options

How the Plans Work

Following is a brief description of the dental plans available through Arizona Benefit Options.

For a complete listing of covered services for each plan, please refer to the plan description located on the website, www.benefitoptions.az.gov. Occasionally, covered services and supplies are subject to change based on the American Dental Association Guidelines. These changes may also result in a change to your copayment.

Prepaid Plans

- You see a Participating Dental Provider (PDP) to provide and coordinate all of your dental care.
- No annual deductible or maximums
- No claim forms

Employers Dental Services (EDS)

Employers Dental Services (EDS) is the largest prepaid dental plan with the largest general dentist network in the State of Arizona. EDS is headquartered in Tucson, Arizona with offices in both Tucson and Phoenix.

Fortis Benefits

Each family member may select his/her own dentist from a group of participating dentists. Each family member may select and change his/her dentist by calling the Fortis Benefits Customer Service number located on the back cover of this guide. Members may self-refer for specialty care.

Indemnity/PPO Plans

- You may see ANY dentist anywhere in the world.
- Deductible and/or out-of-pocket payments apply.
- You have a maximum benefit of $2,000 per person per plan year for dental services and of $1,500 per person per lifetime for orthodontia.
- You may need to submit a claim form for eligible expenses to be paid.
- Benefits may be based on reasonable and customary charges.

Delta Dental

About 80% of Arizona's dentists participate in the Delta Dental Plan and agree to accept Delta's allowable fee as payment in full after any deductibles and/or copayments are met. Amounts in excess of the allowable fee will not be billed to the patient. If you choose to see a non-participating dentist, Delta will still provide benefits, although typically at reduced levels.

MetLife Dental

MetLife participating dental providers (PDP) accept negotiated fees as payment in full after your deductibles and copayments are met. These fees are typically 15–30% below average rates. Noncovered services provided by a PDP dentist are also charged at a lower rate. Covered expenses from a nonparticipating dentist are paid according to established reasonable and customary charges.

If You Live Outside of Arizona

You should select one of the two Indemnity/PPO dental plans. The prepaid plans cover ONLY emergency care outside of Arizona.

Dental Plans Comparison Chart

	Employers Dental Services/EDS*	Fortis Benefits*	Delta Dental	MetLife Dental
PLAN TYPE	Prepaid	Prepaid	Indemnity/PPO	Indemnity/PPO
DEDUCTIBLES	None	None	$50/$150	$50/$150
PREVENTIVE CARE	100% paid, after applicable copay:	100% paid, after applicable copay:		
Office Visit	$5/visit	$5/visit**	100% paid, deductible waived	100% paid, deductible waived
Oral Exam	None	None	100% paid, deductible waived	100% paid, deductible waived
Prophylaxis/cleaning	$5/visit	$3 copay	100% paid, deductible waived	100% paid, deductible waived
Fluoride treatment	None for child	None	100% paid, deductible waived	100% paid, deductible waived
X-rays	None	None	100% paid, deductible waived	100% paid, deductible waived
BASIC RESTORATIVE	Fixed copays:***	Fixed copays:		
Office Visit	$5/visit	$5/visit	80% paid	80% paid
Sealants (to age 19)	$12/tooth	$5/tooth	80% paid	80% paid
Fillings	$12-$25 (amalgam)	$10–$20 (amalgam)	80% paid	80% paid
Extractions	$15 (single)	$15 (single)	80% paid	80% paid
Periodontal	Copay/procedure	$50/quadrant**	80% paid	80% paid
Oral Surgery	Copay/procedure	Copay/procedure**	80% paid	80% paid
MAJOR RESTORATIVE	Fixed copays:***	Fixed copays:		
Office visit	$5/visit	$5	50% paid	50% paid
Crowns	$225-$275 (plus lab fees)	$235	50% paid	50% paid
Dentures	$300 (plus lab fees)	Copay/procedure	50% paid	50% paid
Fixed Bridgework	Copay/Procedure	Copay/procedure	50% paid	50% paid
Crown/Bridge Repair	$5 (plus lab fees)	$20-$45 (plus lab fees)	50% paid	50% paid
Inlays	$112-$125	$130-$240 (plus lab fees)	(Allowance given)	(Covered expense)
ORTHODONTIA	By Treatment Plan:	By Treatment Plan:		
Child	25% discount off Plan Specialist's normal retail charges	25% discount off Plan Specialist's normal retail charges	50% paid	50% paid
Adult	25% discount off Plan Specialist's normal retail charges	25% discount off Plan Specialist's normal retail charges	50% paid	50% paid
TMJ SERVICES	Fixed copays:	Fixed copays:		
Exams, services, etc.	Up to 25% of normal fees	$85-$115	No coverage	No coverage
MAXIMUM BENEFITS	No dollar limit	No dollar limit		
Annual combined preventive, basic and major services	Benefits paid for participating dentists and/or orthodontists only	Benefits paid for participating dentists and/or orthodontists only	$2,000/person	$2,000/person
Orthodontia lifetime			$1,500/person	$1,500/person

* *Requires you to select a Participating Dental Provider (PDP) when enrolling. Out-of-state members are eligible for emergency care only with EDS and Fortis.*

** *A Specialty Benefit Amendment is included in the Fortis Benefits plan that allows patients to receive certain services from Fortis's contracted specialists for a specific copayment rather than the discounted fee.*

*** *Copays listed are for services provided by your EDS General Dentist (PDP). EDS specialists offer up to 25% off their normal office fees for covered procedures.*

Vision Plan

How the Plan Works

You may elect vision coverage for yourself, or for yourself and your family.

The employee pays the full premium for vision coverage.

Avesis Inc. administers the vision plan.

Dual Choice
You may choose to receive services from a **participating network provider or a nonparticipating provider**.

Participating Network Provider Benefits
Receiving services from a participating network provider entitles you to **one of the following three benefit options for the plan year:**

Option 1 – Standard Lenses
You pay an annual $10 copayment for a routine eye exam and receive standard spectacle lenses and a frame, within the plan allowance, at no additional charge.

OR

Option 2 – Contacts
If contacts are elective, you pay an annual $10 copayment for a routine eye exam and receive a $130 allowance toward the cost of the contact lenses and fitting fees.

If Avesis determines contacts are medically necessary, you pay an annual $10 copayment for a routine eye exam and receive your contact lens benefit at no additional cost.

OR

Option 3 – Lasik Surgery
You use a participating network provider and receive a $150 benefit allowance toward the cost of Lasik surgery.

Purchase of Noncovered Options
If you purchase noncovered options (e.g., eyewear) from a participating network provider, the providers have contracted with Avesis to provide these options at a reduced rate to Avesis members.

Nonparticipating Provider Reimbursement Schedule
When visiting a nonparticipating provider, you will be reimbursed for eligible expenses according to the reimbursement schedule below.

You will pay the provider and submit an itemized statement for reimbursement of your eligible vision care expenses. Avesis will reimburse you up to the amount shown in the plan's reimbursement schedule.

When filing a claim for reimbursement, members should include the following information: your member identification number, your name, the patient's name and date of birth, your mailing address, the group name (State of Arizona) and an itemized statement of expenses.

To receive additional information about the vision coverage, please contact Avesis directly at the phone number listed inside the back cover of this Guide.

NONPARTICIPATING PROVIDER FEE SCHEDULE

Service	Reimbursement
Vision Examination	$50
Single Vision Lenses	$30
Bifocal Lenses	$45
Trifocal Lenses	$55
Lenticular Lenses	$110
Frames	$50
Contact Lenses:*	
—Elective	$150
—Medically Necessary	$300
Lasik Surgery	Not covered

Life Insurance Benefits

Basic Life Insurance and AD&D

You are automatically covered for $15,000 of basic life insurance at no cost to you. The State also pays for an additional $15,000 of Accidental Death and Dismemberment (AD&D) insurance coverage. A $15,000 Seat Belt Benefit may also be payable if you die in an automobile accident and are wearing a seat belt. **You are automatically covered in these three programs. No enrollment is necessary.**

Supplemental Life Insurance and AD&D

Supplemental life insurance coverage is available to employees who would like additional life insurance beyond what the State provides. Your cost is based on your age as of October 1st (the first day of the plan year). Your employee supplemental AD&D coverage is the same as the supplemental life amount that you elect.

The maximum amount of supplemental life insurance that you can elect through the State's group plan is three times your annual base salary, or $300,000, whichever is less.

When electing supplemental life, you may increase or decrease your supplemental life coverage, in multiples of $5,000, up to a maximum $20,000 increase per year. You may cancel your pretax supplemental life coverage under certain circumstances. Supplemental life coverage above $35,000 is paid on an after-tax basis. You may cancel this after-tax portion at any time during the year. (For the 2004 Open Enrollment period only, these limits associated with supplemental life insurance increases have been waived. If you choose to increase your life insurance, be sure to elect the entire new amount.)

Dependent Life Insurance

Dependent life insurance coverage is available as a separate election from your Supplemental Life Insurance coverage. You may purchase Spouse and Dependent Life Insurance. Please refer to the eligible dependent section on page 1 of this Guide for a definition of eligible spouse and eligible dependent. Your spouse and eligible children are each insured for the amount you elect: $2,000; $4,000; $6,000; $12,000; or $15,000.

It is important to keep your beneficiary information current.

You may change your beneficiary using the Web or IVR enrollment systems during Open Enrollment. Remember: adding a beneficiary does not automatically delete a previously-designated beneficiary. Therefore, if you wish for the previously-designated beneficiary to be deleted, you must actively do so while enrolling via the website or IVR. If you wish to change your beneficiary outside Open Enrollment, contact your agency benefit liaison.

In the event of your death, employee life and AD&D benefits are paid to your designated beneficiary. If you elect coverage for your dependents, you are automatically the beneficiary for your spouse and children.

Short-Term Disability (STD) Insurance

If you elect Standard Short-Term Disability (STD) insurance and Standard determines that, based on a medical opinion, you are unable to work due to illness, pregnancy, or a nonwork-related injury, you may receive a weekly benefit for up to six months. The STD benefits will pay up to 66-2/3% of your income during disability. The weekly minimum benefit is $57.69; the weekly maximum benefit is $769.27. There are no preexisting condition limitations, but you must meet the actively-at-work provision. The coverage becomes effective when this provision is met.

Your benefits will start on your first day of disability due to accident or the 31st day of disability due to illness or pregnancy, if coverage was elected during your initial new hire/eligibility enrollment period. **If you previously waived STD coverage and enroll during Open Enrollment or due to a Qualified Life Event and become disabled during the first 12 months of coverage, your benefits will start on the 61st day of disability due to illness or pregnancy.** The Standard STD plan provides a Return to Work incentive program. See plan information for details on this program.

Long-Term Disability (LTD) Insurance

As a benefits-eligible employee, you are automatically enrolled in one of the State's two Long-Term Disability (LTD) programs, starting with your first day of work. The retirement system to which you contribute determines the LTD program available to you. Refer to the list below for the name of your LTD program.

- Arizona State Retirement System (ASRS): VPA administered through ASRS
- Public Safety Personnel Retirement System (PSPRS), Correction Officers' Retirement Plan (CORP), Elected Officials' Retirement Plan (EORP), Optional Retirement Plans of the Universities (TIAA-CREF, VALIC, Aetna and Fidelity Investments): Standard Insurance administered through ADOA effective October 1, 2004.

Your LTD benefit will pay up to 66-2/3% of your monthly income during your disability as determined by Standard and based on supporting medical documentation. Your benefits will be subject to an offset based on Social Security payments, retirement benefits and other disability benefits. LTD benefits can be paid until age 65 or until you are able to return to work after your disability. Medical documentation of your disability is required to continue your collection of benefits.

If you are facing a possible long-term disability, you should contact your agency benefit liaison or human resources office by the second or third month of illness or injury for the information you need to apply for LTD benefits. This could include a waiver of insurance premiums (while collecting LTD, the State can waive your life insurance premiums) or life insurance conversion (converting your supplemental policy from a group policy to an individual one).

A waiver or your life and/or disability insurance premiums may be approved. However, **your health insurance premiums are not waived.**

If your disability occurred prior to October 1, 2004, your claim must be filed with CIGNA Long-Term Disability if you are not eligible under VPA.

Flexible Spending Accounts

You have the option to participate in the Medical and/or Dependent Care Flexible Spending Accounts (FSA) administered by ASI. Here's how they work:

- You must enroll every year—your elections from the prior year do not carry over to the new plan year.
- You specify the annual dollar amount of your earnings to be deposited in to each account. This annual amount is deducted in 26 equal payments, one each pay period.
- The amount is deducted from your check before taxes are taken out, lowering your taxable income and possibly lowering your taxes.
- Throughout the year, after you incur an eligible expense, you submit a claim form and your invoices to ASI for reimbursement. The table on page 18 lists sample eligible expenses. To ensure that you will be reimbursed for a given expense, you are encouraged to verify the eligibility of the expense on the ASI website, www.asiflex.com, before incurring the expense.
- ASI reimburses you from the money you have set aside in your Flexible Spending Accounts.
- ASI offers direct deposit for your reimbursement and email notification of your reimbursement.

Use it or Lose it!

It is important to set aside only as much money in your Flexible Spending Accounts as you intend to use each plan year (October 1 through September 30). Internal Revenue Service (IRS) regulations require that all money contributed to your Flexible Spending Accounts must be used to pay for expenses incurred (when the services are provided, not when billed or paid) during that plan year only; otherwise your money is forfeited. Estimate carefully!

Upon Employment Termination

Once your employment is terminated:

- You may continue to submit claims for expenses incurred through your date of termination.
- You forfeit any remaining monies unless you elect to continue your FSA contributions through COBRA and continue to receive reimbursements for eligible expenses incurred through the end of the plan year—September 30th. If you do elect to continue your FSA through COBRA, your contributions will be made on a post-tax basis.

Questions to Ask Yourself Before Enrolling In Flexible Spending Accounts

To help you plan, ask yourself these questions:

- *What were my out-of-pocket health care and dependent care costs last year?*
- *What do I expect my out-of-pocket health care and dependent care expenses to be next year? If you spend $300 or more each year on medical, dental or vision visits/charges, your FSA can save you at least $75 in taxes on $300 in expenses.*
- *Am I expecting to incur some health care costs that are not totally covered by my benefits (e.g., orthodontia)?*
- *Does my spouse have Flexible Spending Accounts available through his or her employer? If so, how do we want to coordinate our accounts?*

Medical and Dependent Care Flexible Spending Accounts

	Medical Care	Dependent Care
Maximum contributions	$5,000.00 annually	$5,000.00 annually ($2,500.00 if married and filing separately)
Minimum contributions	$130.00 annually	$260.00 annually
Use of the account	■ To pay (with pretax money) for health-related expenses that are not covered or only partially covered by your health plans, including expenses for your spouse or children not enrolled in your medical, dental, or vision plans ■ To pay for over-the-counter medications that will be used to treat an existing or imminent condition	■ Expenses for care, of an eligible dependent, that is provided inside or outside your home ■ Care provided for your children under age 13 for whom you have custody, for a physically or mentally handicapped spouse or other dependents who spend at least eight hours a day in your home ■ Dependent care provided so that you can work
Samples of eligible expenses	■ Copayments ■ Deductibles ■ Charges above reasonable and customary limits ■ Dental fees ■ Eyeglasses, exam fees, contact lenses and solution, Lasik eye surgery ■ Orthodontia ■ Nonprescription medications (e.g., cold medicines, allergy medicines, antacids, pain relievers)	■ Services provided by a day care facility. Must be licensed if the facility cares for six or more children ■ Babysitting services while you work ■ Practical nursing care ■ After-school care ■ Preschool
What's not covered	■ Premiums for medical or dental plans ■ Items not eligible for health care tax exemptions by IRS (e.g., cosmetic surgery) ■ Long-term care expenses	■ Private school tuition including kindergarten ■ Overnight camp expenses ■ Babysitting when you are not working ■ Transportation and other separately billed charges ■ Residential nursing home care
Restrictions/other information	■ See IRS Publication 502 (expenses in this plan qualify based on when the services are provided regardless of when you pay for the expense) or go to ASI's website at www.asiflex.com for specific details on what expenses are allowed ■ You cannot transfer money from one account to the other ■ Your election amount may be increased (but not decreased) if you have a Qualified Life Event	■ See IRS Publication 503 (expenses in this plan qualify based on when the services are provided regardless of when you pay for the expense) or go to ASI's website at www.asiflex.com for specific details on what expenses are allowed ■ You may not use the account to pay your spouse, your child who is under the age of 19 or a person whom you could claim as a dependent for tax purposes ■ You cannot change your election amount unless you have a Qualified Life Event

Life Events/Mid-Year Changes

You cannot change your elections to your Medical or Dependent Care Flexible Spending Accounts after Open Enrollment unless you have a Qualified Life Event as defined by the IRS, that causes you, your spouse or a dependent to gain or lose coverage. The requested change must correspond with the gain or loss of coverage and must be submitted in writing within 31 days of the change. If you have a Qualified Life Event:

- You may increase the amount in either account or both: Medical Flexible Spending Account and/or Dependent Care Flexible Spending Account.
- Midyear reductions to the Medical Flexible Spending Account are not permitted.
- Midyear reductions to the Dependent Care Flexible Spending Account are permitted.

Tax Credit

There are additional IRS rules that apply to your Dependent Care Flexible Spending Account contributions. You may be eligible to claim the dependent care tax credit on your Federal income tax return. You may want to consult a tax advisor to determine whether participating in the Dependent Care Flexible Spending Account or taking the dependent care tax credit gives you the greater advantage.

Using Your Flexible Spending Accounts

You have several options for obtaining and filing a claim against your Flexible Spending Account. You may obtain a claim form in the following ways:

- On the web—You may download a claim form at www.asiflex.com.
- On the phone—You may call ASI at 1-800-659-3035 and request a claim form.
- By mail—You may request a claim form by sending a written request to:
  P.O. Box 6044
  Columbia, MO 65205.

You will need to fill out your claim form and attach copies of invoices for services you received. Mail the claim form to the address shown above and wait to receive your reimbursement by direct deposit or check.

You may sign up for direct deposit during the Open Enrollment process. If you wish to start direct deposit of your reimbursements after the Open Enrollment period, you will need to do so through ASI. The direct deposit request form is available at www.asiflex.com. You may also have your statements sent to you by email. Go to www.asiflex.com and follow the links to sign up. See your agency benefit liaison if you have questions or problems obtaining or submitting a claim.

COBRA Continuation of Coverage Notice

Under a Federal law commonly called COBRA, the State of Arizona (hereinafter referred to as Us and We) offers employees and their families the opportunity to extend their group health coverage (COBRA coverage) at group rates in certain instances when coverage under the plan would otherwise end. This notice is addressed to you and, if applicable, your spouse, and is intended to inform both of you in a summary fashion of your rights and obligations under the continuation coverage provisions of the law. Both you and your spouse should take the time to read this notice carefully. This is also in the plan description for your chosen coverage under Arizona Benefit Options (the Plan).

Eligibility

- You have 60 days from the date of COBRA notification to elect coverage.
- The effective date of your COBRA coverage will be the date following the termination of your employment. You will be responsible for the premiums retroactive to the COBRA effective date.
- As a dependent, the effective date of your COBRA coverage will be the date following your eligibility as a dependent terminates. You will be responsible for the premiums retroactive to the COBRA effective date.
- There will be no break in coverage. Claim payments will not be made until premium payments are deposited.
- If your employment is terminated following a leave without pay status, and you did not pay your premiums for the leave-without-pay coverage period, the effective date of your COBRA coverage will be the date following termination of your active employment.
- If you are an employee with coverage under the Plan, you have a right to choose COBRA coverage if you lose coverage under the Plan because of a reduction in your hours of employment or the termination of your employment, unless it is because of your gross misconduct.
- If you are an employee's spouse who is covered by the Plan, you are a qualified beneficiary. This means you have a right to make your own choice about COBRA coverage if you lose group health coverage under the Plan for any of the following reasons:
  - —death of your spouse;
  - —termination of your spouse's employment (for reasons other than gross misconduct);
  - —reduction in your spouse's hours of employment;
  - —divorce or legal separation from your spouse; or
  - —your spouse becomes entitled to Medicare.
- An employee's dependent child who is covered by the Plan is also a qualified beneficiary with the right to continue coverage if group health coverage under the Plan is lost for any of the following reasons:
  - —death of the employee (parent);
  - —termination of the parent's employment (for reasons other than gross misconduct);
  - —reduction in the parent's hours of employment;
  - —parents' divorce or legal separation;
  - —the parent becomes entitled to Medicare; or
  - —the dependent ceases to be a dependent child as defined by the Plan.

How Long COBRA Coverage Lasts

If you lose your coverage under the Plan because of a termination of employment or reduction in hours, you and your eligible family members can maintain COBRA continuation coverage for a maximum period of 18 months from the date of that event.

If an employee's spouse and covered dependents lose their coverage under the Plan because of the employee's death or entitlement to Medicare, the employee's legal separation or divorce, or because the employee's child is no longer a dependent under the Plan, eligible family members may maintain COBRA coverage for a maximum period of 36 months from the date of that event.

The law also provides that COBRA coverage may be cut short for any of the following reasons:

- —the Employer no longer provides group health coverage to any of its employees;
- —you do not pay the amount due for your COBRA coverage on time;
- —you or one of your covered family members become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition that you or they may have or, that, by law, may no longer exclude or limit coverage for any of your or their preexisting conditions; or
- —you or one of your covered family members become entitled to Medicare.

Extended COBRA Coverage

In addition, during or before an 18-month period of COBRA coverage, the Social Security Administration makes a formal determination that you or a covered dependent spouse or child are totally and permanently disabled, so as to be entitled to Social Security Disability Income benefits, the 18-month maximum period of COBRA coverage can be extended for up to 11 more months, for all qualified beneficiaries who have elected COBRA coverage. The cost of coverage during the additional 11-month period of COBRA coverage may be considerably higher than the cost for the coverage for the first 18 months. This extension is available if:

- —the Social Security Administration determines that the individual's

disability began no later than 60 days after the employee's employment was terminated or his/her hours were reduced; and
— you or another member of your family notifies Us of the disability determination by the Social Security Administration before the end of the 18-month COBRA coverage period.

Changing your COBRA Benefits

In order to have the chance to continue health coverage after a divorce, legal separation, or a child ceasing to be a dependent, the employee and/or the family member must inform Us, through your agency benefit liaison, no later than 60 days after the event. If notice is not received by the end of that 60-day period, the affected spouse or dependent will not be entitled to choose COBRA coverage.

When notified that one of these events has happened, We will give you or your covered dependents the information and forms needed to elect COBRA coverage. Under the law, you and/or your covered dependents have at least 60 days from the date you or they would lose coverage because of one of the events described above, to inform Us that you or they want to elect COBRA coverage.

COBRA coverage may be elected for some members of the family but not others (including one or more dependents, even if the employee does not elect it), as long as those for whom it is chosen were covered by the Plan on the date of the event (termination of employment, death, divorce, etc.) that led to the loss of regular health coverage under the Plan. A parent may elect or reject COBRA coverage on behalf of dependent children living with him/her.

If while you are enrolled for COBRA coverage, you marry, have a newborn child or have a child placed with you for adoption, you may enroll that spouse or child for coverage for the balance of the period of your COBRA coverage, by doing so within 30 days after the birth, marriage or placement. Adding a child or spouse may cause an increase in the amount you must pay for COBRA coverage. Any qualified beneficiary can add a new spouse or child to his/her COBRA coverage, but the only newly-added family members who have the rights of a qualified beneficiary, such as the right to stay on COBRA coverage longer in certain circumstances, are natural or adopted children of the former employee.

IF YOU DO NOT CHOOSE COBRA COVERAGE WHEN IT IS OFFERED TO YOU, YOUR COVERAGE UNDER THE PLAN WILL END.

A Second Qualified Life Event

A 36-month extension from the employee's termination of employment or reduction in hours may be granted. This extension only applies to qualified beneficiaries, including children of the employee who were born or adopted while the employee was on COBRA coverage.

How COBRA Works

If you choose COBRA coverage, you will be entitled to the same type of coverage that you had before the event that triggered COBRA, i.e., you can choose to take medical and/or dental coverage. If there is a change in the coverage provided under the Plan to similarly-situated active employees and their families, that same change will be made in your COBRA coverage. If you choose COBRA coverage, you must pay for it, as explained in this notice.

How Do You Pay?

If you become entitled to COBRA coverage, by law you will have to pay all of the cost of your COBRA coverage. You are charged the full amount of the cost for similarly-situated employees or families — both the employer's and the employee's shares — plus an additional 2% administrative fee.

Payment Schedule

You must make the first payment (from the date coverage ended due to the qualifying event) within 45 days of notifying the plan administrator of selection of COBRA coverage. Thereafter, premiums are due on the first day of each month of coverage. After your first premium payment, you may have a grace period of 30 days from the usual due date to pay the premiums.

THE PLAN AND YOUR CARRIER WILL NOT BE ABLE TO CONFIRM THAT YOU ARE ENTITLED TO COVERED SERVICES UNTIL THE CARRIER HAS RECEIVED YOUR PREMIUM FOR THE MONTH IN WHICH THE CARE IS TO BE PROVIDED.

Converting to an Individual Plan

At the end of the 18-month or 36-month period of COBRA coverage, you will be allowed to enroll in an individual conversion health plan as provided by the carrier if that right is still offered by the Plan when your COBRA coverage period expires.

Questions

Please contact your agency benefit liaison or the ADOA Benefits Office with any questions regarding COBRA coverage.

NOTICE OF THE ARIZONA BENEFIT OPTIONS PROGRAM PRIVACY PRACTICES

The administrators of Arizona Benefit Options know that the privacy of your personal information is important to you. This Notice describes how medical information about you may be used and disclosed, how you may gain access to this information, and the measures taken to safeguard your information. Throughout this Notice, all references to Arizona Benefit Options refer to the administrators of the Program. Please review it carefully.

USE AND DISCLOSURE OF HEALTH INFORMATION

Arizona Benefit Options may use your health information for purposes of making or obtaining payment for your care, and for conducting health care operations. Arizona Benefit Options has established a policy to guard against unnecessary disclosure of your health information. For purposes of this Notice, health information refers to any information that is considered protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act ("HIPAA") of 1996.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Make or Obtain Payment Arizona Benefit Options may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, Arizona Benefit Options may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations Arizona Benefit Options may use or disclose health information for its own operations to facilitate the administration of Arizona Benefit Options and as necessary to provide coverage and services to all Arizona Benefit Options' participants. Health care operations include activities such as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Reviews and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning analyses and formulary development. In addition, summary health information may be provided to third parties in connection with the solicitation of health plans or the modification or amendment of the existing plan.
- Business management and general administrative activities of Arizona Benefit Options, including customer service and resolution of internal grievances.

As an example, Arizona Benefit Options may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Treatment Alternatives Arizona Benefit Options may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services Arizona Benefit Options may use or disclose your health information to provide you with information on health-related benefits and services that may be of interest to you.

When Legally Required Arizona Benefit Options will disclose your health information when it is required to do so by any federal, state or local law.

To Conduct Health Oversight Activities Arizona Benefit Options may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. Arizona Benefit Options, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings As permitted or required by state law, Arizona Benefit Options may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when Arizona Benefit Options makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes As permitted or required by state law, Arizona Benefit Options may disclose your health information to a law enforcement official for certain law enforcement purposes, including but not limited to if Arizona Benefit Options has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In the Event of a Serious Threat to Health or Safety Arizona Benefit Options may, consistent with applicable law and ethical standards of conduct, disclose your health information if Arizona Benefit Options, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions In certain circumstances, federal regulations require Arizona Benefit Options to use or disclose your health information to facilitate specific government functions related to the military and veterans, to national security and intelligence activities, to protective services for the president and others, and to correctional institutions and inmates.

For Workers Compensation Arizona Benefit Options may release your health information to the extent necessary to comply with laws related to workers compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, Arizona Benefit Options will not disclose your health information without your written authorization. If you authorize Arizona Benefit Options to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that Arizona Benefit Options maintains:

Right to Request Restrictions You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on Arizona Benefit Options' disclosure of your health information to someone involved in the payment of your care. However, Arizona Benefit Options is not required to agree to your request.

Right to Receive Confidential Communications To safeguard the confidentiality of your health information, you may request that Arizona Benefit Options communicate in a specified manner or at a specified location. Alternatively, for example, you may request that all health information be mailed to your work location rather than your home. If you wish to receive confidential communications, please make your request in writing. Arizona Benefit Options will accommodate reasonable requests, when possible.

Right to Inspect and Copy Your Health Information You have the right to inspect and copy your health information. If you request a copy of your health information, Arizona Benefit Options may charge a reasonable fee for copying, assembling costs and, if applicable, postage associated with your request.

Right to Amend Your Health Information If you believe that your health information records are inaccurate or incomplete, you may request that Arizona Benefit Options amend the records. That request may be made as long as the information is maintained by Arizona Benefit Options. Arizona Benefit Options may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by Arizona Benefit Options, if the health information you are requesting to amend is not part of Arizona Benefit Options' records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if Arizona Benefit Options determines the records containing your health information are accurate and complete.

Right to an Accounting You have the right to request a list of disclosures of your health information made by Arizona Benefit Options for any reason other than for treatment, payment or health operations. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. Arizona Benefit Options will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. Arizona Benefit Options will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically.

DUTIES OF ARIZONA BENEFIT OPTIONS

Arizona Benefit Options is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. Arizona Benefit Options is required to abide by the terms of this Notice, which may be amended from time to time. Arizona Benefit Options reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If Arizona Benefit Options changes its policies and procedures, Arizona Benefit Options will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to Arizona Benefit Options and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Arizona Benefit Options encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT INFORMATION

For more information or for further explanation of this document, you may contact an Arizona Benefit Options representative at 602-542-5008 (outside the Phoenix area, toll free at 1-800-304-3687), or by email at beneissues@ad.state.az.us. You may also obtain a copy of this Notice at our web site at www.benefitoptions.az.gov. The ADOA Privacy Officer may be contacted at 100 N. 15th Avenue, Suite 401, Phoenix, Arizona, 85007, by phone at 602-542-1500, or by fax at 602-542-2199.

EFFECTIVE DATE

This Notice is effective April 14, 2003.

Important Contact Information

Remember, when calling the carriers, tell them that you are a State of Arizona employee.

Contact	Phone Number	Web Address
Plan Administrators:		
Medical Plans: Arizona Foundation, RAN+AMN (HMA), Schaller Anderson Healthcare, Beech Street		
■ Arizona Benefit Options - Harrington	■ 1.888.999.1459	www.myazhealth.com
UnitedHealthcare Medical Plan		
■ UnitedHealthcare	■ 1.800.896.1067	www.myuhc.com
Pharmacy		
■ Walgreens Health Initiatives	■ 1.866.722.2141	www.mywhi.com
Dental Plans		
■ Delta Dental	■ 1.800.352.6132	www.deltadentalaz.com
■ Employers Dental Services (EDS)	■ 1.800.722.9772	www.mydentalplan.net
■ Fortis Benefits	■ 1.800.443.2995	www.fortisbenefitsdental.com
■ MetLife Dental	■ 1.800.942.0854	www.metlife.com/dental
Vision Plan - Avesis, Inc.	■ 1.800.828.9341	www.avesis.com
Flexible Spending Accounts - ASI		
■ InfoLine	■ 1.800.366.4827	www.asiflex.com
■ Member Services	■ 1.800.659.3035	Email: asi@asiflex.com
Life & Short-Term Disability Plans - Standard Insurance Company	■ 1.800.447.3146	
ADOA Benefits Office	■ (602) 542.5008	www.benefitoptions.az.gov
100 N. 15th Ave. #103	OR	
Phoenix, Arizona 85007	■ 1.800.304.3687	Email: beneissues@ad.state.az.us

Photos by Annette Fettig

This book featuring State employees was designed by State employees, for State employees.

state of arizona
benefit options
medical • dental • vision • wellness
"Your Health Matters"